DE4: Primary Care in the San Francisco Health Network:
Achieving the Quadruple Aim through Innovation and Engagement

Institute for Healthcare Improvement
17th Annual Summit on Improving Patient Care in the Office and Community
March 21, 2016

Disclosures

We have nothing to disclose
Session objectives

Participants will:

Develop ideas to improve the health of high-risk populations in safety net healthcare settings

Detail specific approaches to improve patient experience in safety net healthcare settings

Identify quadruple aim strategies that can be implemented in participants’ organizations

Today’s presenters

Jonathan Albright
Analyst, Operations

Amy Petersen, MPH
Analyst, Care Experience

Elizabeth Davis, MD
Medical Director, Care Coordination

Anna Robert, RN, DrPH
Director, Care Coordination

Hali Hammer, MD
Director of Primary Care

Judith Sansone, RN, MS
Director of Nursing
SFHN is the vertically integrated delivery system of the San Francisco Department of Public Health.

SFHN is clinically and financially accountable to provide coordinated health services to the diverse and vulnerable individuals it serves and to improve the health of communities.

Scope of services

SFHN provides:

• Primary care to 70,000 patients
• Comprehensive specialty, diagnostic, emergency, inpatient and trauma care
• Acute care hospital, long term care skilled nursing facility, and home nursing services
• Full spectrum behavioral health & substance abuse services
• Wide range of maternal, child, and adolescent health services
• Comprehensive health care for incarcerated people
• Extensive array of homeless health services
Vision of SFHN Primary Care

1st CHOICE FOR HEALTH CARE AND WELL-BEING

Improve The Health Of The Patients We Serve
Optimize Access, Operations, and Cost-effectiveness
Ensure Excellent Patient Experience

SAFETY
QUALITY
CARE EXPERIENCE
PEOPLE DEVELOPMENT
FINANCIAL SUSTAINABILITY
EQUITY

BUILD A FOUNDATION OF A HEALTHY, ENGAGED, AND SUSTAINED PRIMARY CARE WORKFORCE

WE PROVIDE HIGH QUALITY HEALTH CARE THAT ENABLES ALL SAN FRANCISCANS TO LIVE VIBRANT, HEALTHY LIVES
Q & A

Access and capacity standardization

**2005-09**
- Provider empanelment
- Appointment & productivity standards
- PCP panel size per FTE

**2010-12**
- Weighted panel calculations
- PCP continuity report
- PC data wall

**2013-14**
- PC integration
- Staffing capture tool
- Enrollment capacity calculator
- Standardized appointment templates

**2015-16**
- Weekly access scorecard
- Access dashboard
### Tool: monthly enrollment capacity calculator

**Weighted panel size**
- Staffing ratios
- Attrition rates
- Enrolled but not yet seen

<table>
<thead>
<tr>
<th>New Apps Needed to Meet Expected Demand*</th>
<th>Enrollment Numbers**</th>
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<tbody>
<tr>
<td><strong>Expected New Apt Demand</strong></td>
<td><strong>Reserved for Non-Enrolled</strong></td>
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<td>Castro Mission</td>
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<td>FHC</td>
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### Tool: weekly access scorecard

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<td>Curry</td>
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<td>TWHHC</td>
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<td>CHC</td>
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* Green flag: Keep up the good work
* Yellow flag: Caution: if you fail you need centralized support or are headed toward a red flag please contact PC Admin team within a week.
* Red flag: Crisis zone; plan of action, including an ask for any centralized support is due to PC Admin team Tuesday by 3PM.
Primary Care Access Dashboard

Access: providing care when patients need/want it

Transitioning from safety net model to integrated network of “choice”

Low scores for patient satisfaction for access

Show rate: large variation - 50-90%

Centralized nurse advice line, telephone providers
Access: new patients

San Francisco Health Network Waiting List Trends: October 2012 - Current

Access: urgent appointments

Weekly Urgent Appt Access: All Clinics, Appt in Medical Home or Telephone Provider
How to provide care when patients need or want

I. Background

- We are not meeting regulatory requirement of routine appointment access within 14 days and 48 hours for urgent appointment access.
- Our system needs to compete for patients in today’s health care environment.
- Our system is a network of care (primary, hospital, specialty) and we need to provide coordinated care for our patients.
- Our system needs to reduce new patient design in access.
- New patient experience is unknown.
- Our system has a lot of ideas on how to improve patient experience.

II. Current Conditions

- New patients and reports increase patients.
- Patients need to improve access to care.

III. Analysis: Fish Bone from Front Office Leaders July 2015

What By Whom When

Develop actionable access dashboard Jonathan January 2016

Introduce regular review and discussion of data in:
- Front Office Leaders meeting
- Clinic management team meetings, every other month

Flip visit standard work
a) Improvement workshop a) Kathryn facilitate improvement workshop a) November 2015
b) Pilot standard work b) Kathryn, Shirley b) January 2016
c) Roll out standard work c) Kathryn, Shirley c) February 2016

Develop and implement role of practice manager Kathryn with clinic Medical Directors April 2016

IV. Proposed Countermeasures

V. Plan

<table>
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<th>K Horner &amp; A Robert</th>
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V. Plan

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Robust reminder calls:

- a) Develop standard work a) Kathryn facilitate improvement workshop a) February 2016
b) Coleman training for all staff b) Kathryn b) March 2016
c) Show data sub-dashboard c) Jonathan c) April 2016
d) PAC involvement d) Lucia d) April 2016
e) Include in standard work in progress monthly review e) Kathryn e) May 2016

3. Scrubbing

- a) Develop standard work a) Kathryn facilitate improvement workshop a) March 2016
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Centralized Call Center/NAL work

- a) Scripting a) CCC/NAL leadership a) February 2016
b) Increase non-face to face visits b) Anna/Elsa/NAL b) June 2016
c) Appointment control/standardized scheduling c) Anna/Kathryn/CCC c) TBD

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3/7/2016
Patient engagement: satisfaction and loyalty

% interested in changing place of care (among low-income Californians)

- All: 55%
- Dissatisfied with current care: 83%
- Rate care as good: 40%
- Rate care as excellent or very good: 45%
Predictors of satisfaction

Enhance Ability to Communicate
To effectively connect with patients, staff and providers must be able to clearly explain situations, invite questions, and help patients comfortably express their needs and preferences.

Implement New Models of Care
Utilizing a team-based care model helps build a sense of connectedness between patients and their care facilities, enhances patients' information, and bolsters satisfaction.

Help Patients Take an Active Role
Encouraging patient involvement by simply inviting them to participate in decisions about their care helps patients feel more involved and satisfied with their role in decision making.

Use Mobile and Web Technologies
Communicating through email and text messages, and providing online information, communication resources and decision aids, can help providers build engagement and improve the patient experience.

Source: Blue Shield of California Foundation, Delivering on Promise (Langer and Associates)

Engaging patients as partners

2014
4 of 15 sites with existing Patient Advisory Councils
Interest in scale, standardization, and spread

2015
Incentive $ budgeted
Central Lead + .70 coordination support
3 learning sessions

2016
89 advisors activated
Centrally coordinated improvement efforts involve Patient Advisors
Partnering with patients: Patient Advisory Councils

Goal is to partner with patients in improvement work focused on patient satisfaction drivers

- By December 2016, PC Leadership Team-led workgroups will partner with Patient Advisors on access, customer service, and team-based care focused improvements

Primary Language
- English: 2%
- Spanish: 14%
- Cantonese/Mandarin: 14%
- Other: 69%

Race/Ethnicity
- Black/African American: 3%
- White: 23%
- Asian: 18%
- Hispanic/Latino: 14%
- Other: 2%

Standard work for patient partnerships

Engage early and often
Incorporate design thinking
Promote development opportunities for staff
Make changes visible
CG CAHPS dimensions and team-based care

- Service
- Care Coordination
- Provider Relationship
- Timely Access
- Provider Rating 9 or 10

Team-based care: consider the patient perspective

- Primary Care Provider
- Behavioral Health
- Auxiliary Services
- Practice Admin / Front Office
- Pharmacist
- Medical assistants
- Nurse
CARE EXPERIENCE

METRIC:
Likelihood to Recommend

Why we measure this:
The percentage of patients giving a 9 or 10 rating on likelihood to recommend their health center as a place for care to family and friends tells us about overall patient experience.

Target:
Either relative improvement goal of 5% over baseline or reaching threshold of 75%.

This month:
67.6%
75% GOAL

2% Under baseline

When the Lee family recommends their clinic to friends and family, our ties to the community grow stronger.

Q & A
Transitions in care

- 2012: Care Transitions Taskforce convened and implemented Complex Care Management
- 2013: California Quality Collaborative Moore Foundation grant
- 2014: SF Health Plan performance improvement measure, pilots at 4 clinics
- 2015-16: SFHN PC driver metric, standardization across all clinics
- No data at clinic level
- Discharge database, clinic level data
**Standard work**

- Appointment within 7 days of discharge
- Phone call within 72 hours of discharge

**Team-based care**

- Willing to see other PCPs’ patients post-discharge
- Help with transportation and eligibility issues
- Scheduling patients
- Post-discharge phone calls
- Centralized Call Center point of contact for outside hospitals
- Pharmacy post-discharge visits
- RN post-discharge visits
Post-discharge phone calls

• Call within 72 hours of discharge
• HW, MA, or RN
• Scripted
  • Appointments
  • Medications
  • Red flags
  • Primary care access

Care transitions taskforce

• SFHN-wide taskforce
• Inpatient and outpatient stakeholders
• Interprofessional
• Executive sponsorship
Care transitions discharge worklist

Data-driven improvement
Post-discharge follow-up rate and readmission rate

Q & A
Population health: data-driven improvement

2005
- Targeted QI initiatives
- 1115 waiver begins (2010)
- Empanelment

2011
- System wide goals
- Engaged leadership
- Project based outreach

2013
- Birth of SFHN and Primary Care integration
- Lean Management System - strategic planning begins

Access Database  i2i tracks/EHR rollout begins  EHR and i2i optimization continue

Primary Care priority: equity and hypertension

Primary care driver metric: blood pressure control
“it’s not just for diabetics anymore”

- BAAHI – Black African American Health Initiative
- PHASE IV – Preventing Heart Attacks and Strokes Everyday
- Team-based care
Blood pressure control

Current: 65.7% Total (18173)
Baseline: 60.9%
Goal: 65%

Blood pressure control by race

Asian(5964) Black(4199) White (3344) Hispanic (3555)
Team-based care

Targets for 2016 and beyond

• Blood pressure control target of 70% or 15% relative improvement for all patients

• Blood pressure control target of 65% or 20% relative improvement for African American patients

• Outreach and engagement of patients enrolled in our clinics but not yet seen
How will we get there?

• More team-based care
  • Performance improvement workshop for RN HTN visits—Nurses, Pharmacists
  • Health coaching with outreach to African American patients and use of local navigators and staff as coaches—front line staff, community members
  • Home blood pressure monitoring—Health Coaches, patients
  • Risk stratification of HTN patients for RN, PharmD, PCP visits
  • Medical Assistant report to provide feedback about completion of standard work—Nurses, Medical Assistants, QI leads

Primary Care True North metrics

<table>
<thead>
<tr>
<th>SFHN Strategic Theme</th>
<th>True North Metric (what’s actually being measured?)</th>
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<tbody>
<tr>
<td>Financial Sustainability</td>
<td>Annual revenue for rendered services</td>
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<tr>
<td>Care Experience</td>
<td>Would recommend SFHN as a place to work (CG CPHS)</td>
</tr>
<tr>
<td>Quality &amp; Equity</td>
<td>Improve health &amp; reduce disparities (PH composite)</td>
</tr>
<tr>
<td>Equity</td>
<td>Reduce disparities and eliminate bias in hiring</td>
</tr>
<tr>
<td>Develop People</td>
<td>Staff engagement (Gallup composite)</td>
</tr>
<tr>
<td>Safety</td>
<td>Timely coordination of care to reduce high risk events: timely lab review, reduce re-admissions</td>
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Alignment leads to progress

Alignment → Collective Progress

Q & A
THANK YOU!

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